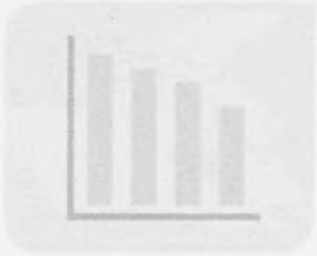
Pan-Canadian Health Inequalities Reporting Initiative

Key Health Inequalities in Canada

A National Portrait

Executive Summary



Public Health Agency of Canada
Agence de la santé publique du Canada

Pan-Canadian Public Health Network
Partners in Public Health

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EXECUTIVE SUMMARY

ACRONYM	FULL NAME
CIHI	Canadian Institute for Health Information
FNIGC	First Nations Information Governance Centre
HIR	Health Inequalities Reporting
PHAC	Public Health Agency of Canada
PHN	Pan-Canadian Public Health Net
RHS	First Nations Regional Health Survey
SHS	Second-Hand Smoke
SRMH	Self-Rated Mental Health
WHO	World Health Organization

Health inequalities in Canada exist, are persistent, and in some cases, are growing (1-3). Many of these inequalities are the result of individuals' and groups' relative social, political, and economic disadvantages. Such inequalities affect peoples' chances of achieving and maintaining good health over their lifetimes (4). Where inequalities in health outcomes or in access to the resources that support health are systematic (that is, the patterns of difference are consistently observable between population groups) and can plausibly be avoided or ameliorated by collective action, they may be deemed unjust and *inequitable* (5-7).

This report describes the magnitude and distribution of key health inequalities in Canada, a critical step in facilitating action to advance health equity. It is a product of the Pan-Canadian Health Inequalities Reporting (HIR) Initiative, a collaborative undertaking by the Public Health Agency of Canada (PHAC), the Pan-Canadian Public Health Network (PHN), Statistics Canada, and the Canadian Institute for Health Information (CIHI).

The HIR Initiative aims to strengthen health inequalities measurement, monitoring, and reporting capacity in Canada. It is intended to support surveillance and research activities, inform policy and program decision making to more effectively reduce health inequalities, and enable the monitoring of progress in this area over time.

The HIR Initiative's theoretical foundations are based on a conceptual framework originally developed by the World Health Organization (WHO) Commission on Social Determinants of Health (8). This framework highlights the critical roles that broad social, economic, and political factors (e.g. systems of governance; macroeconomic, social, and public policies; and societal values and norms) play in generating and reinforcing societal hierarchies. These differences in socioeconomic positions shape the health-influencing social and physical conditions in which individuals are born, grow, live, work, and age. These conditions include material circumstances (e.g. living and housing standards, workplace conditions, neighbourhood amenities and safety); psychosocial factors (e.g. job strain, social connectedness or isolation, access to social support); health behaviours (e.g. diet, physical activity, tobacco and alcohol consumption); and biological (including genetic) factors. The interactions between these various domains are the means by which inequitable social processes are translated into inequities in health and well-being outcomes.

Building on a set of indicators proposed by PHN in 2010, the HIR Initiative brought together data on more than 70 indicators of health outcomes, risk factors, and social determinants of health. These indicators were systematically disaggregated across a range of socioeconomic and sociodemographic variables ("social stratifier groups") meaningful to health equity (see Figure 1).

FIGURE 1

Summary of the analytical approach for the HIR Initiative

INDICATORS

HEALTH STATUS

Including indicators for:

- Life expectancy and health-adjusted life expectancy
- Mortality and disability
- Perceived physical and mental health
- Infectious and chronic diseases

HEALTH DETERMINANTS

Including indicators for:

- Health behaviours
- Early childhood development
- Physical and social environments
- Working conditions
- Access to health care
- Social protection
- Social inequities

SOCIAL STRATIFIERS

SOCIOECONOMIC STATUS

- Income
- Education
- Employment
- Occupation
- Material and social deprivation

INDIGENOUS PEOPLES

- First Nations
- Inuit
- Métis

PLACE OF RESIDENCE

- Rural/Urban

POPULATION GROUP

- Age
- Immigrant status
- Sexual orientation
- Functional health
- Cultural/racial background

SEX: Male or Female

JURISDICTION: National or Provincial/Territorial

The resulting portrait of the state of health inequalities in Canada is available through the Health Inequalities Data Tool, an online interactive database (http://infobase.phac-aspc.gc.ca/health-inequalities).

Drawing from the full set of health outcome and health determinant indicators in the Data Tool, the present report highlights results for 22 indicators that represent some of the most pronounced and widespread health inequalities in Canada, as potential priority areas for initial action (see Figure 2).

FIGURE 2

Indicator list for the Key Health Inequalities in Canada report

INDICATOR DOMAIN	INDICATOR
Health Outcomes	• Life expectancy at birth • Health-adjusted life expectancy • Infant mortality • Unintentional injury mortality • Suicide mortality • Perceived mental health (fair or poor) • Mental illness hospitalization rate • Arthritis • Asthma • Diabetes (excluding gestational) • Disability • Lung cancer incidence • Obesity • Oral health (inability to chew) • Tuberculosis
Health Determinants A: Daily Living Conditions	• Alcohol use – heavy drinking • Smoking • Core housing need • Exposure to second-hand smoke in the home
Health Determinants B: Structural Drivers	• Early childhood development (Early Development Instrument) • Food insecurity • Working poor

Health determinant indicators can be daily living conditions such as high alcohol consumption; smoking, and exposure to second-hand smoke; early childhood development; and core housing need. Similarly, structural drivers, for example, household food insecurity and working poverty, can be health determinant indicators.

› The indicators featured in this report were selected based on several considerations, including whether they:

› reveal inequalities that are particularly pronounced and widespread across population groups;

› cover a range of health outcomes, health behaviours and broader social determinants of health;

› allow for systematic disaggregation of data across **key population groups**; and

› are policy-relevant and actionable.

BOX 1
SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUALITIES– INDIGENOUS PERSPECTIVES

Prepared by the First Nations Information Governance Centre and Métis National Council

Traditionally, Indigenous peoples have viewed health in a balanced and holistic way, with connections between spiritual, emotional, mental and physical dimensions. Similarly, the determinants of Indigenous health are seen as closely interconnected (9-11). They include *proximal determinants* (e.g. health behaviours), *intermediate* determinants (e.g. community infrastructure, kinship networks, relationship to the land, language, ceremonies, and knowledge sharing), and *structural* determinants (e.g. historical, political, ideological, economic, and social foundations, including elements of strength such as Indigenous world views, spirituality, and self-determination) (11,12). From the Métis perspective, it is important to integrate Indigenous and Western knowledge development approaches in order to draw holistically from the narratives, experiences, information and data available from both of these ancestral 'ways of knowing' (10).

In order to understand health inequalities between Indigenous and non-Indigenous peoples, it is necessary to contextualize them within the historical, political, social, and economic conditions that have influenced Indigenous health. The colonial structure, which sought to assimilate Indigenous peoples into the dominant Euro-Canadian culture, has been largely responsible for destabilizing the determinants of Indigenous health (13). The forced displacement of First Nations into remote communities and reserves that were uninhabitable and lacking in resources; the claiming of traditional areas rich in resources by colonial powers; the oppression of First Nations created by the *Indian Act*; the damaging legacy of Indian Residential Schools and the Sixties Scoop; systemic discrimination against all Indigenous peoples across social, criminal justice, health care, and employment environments; and the lack of public or private economic development investments for Indigenous communities are all examples of how the colonial structure have contributed to the health inequities that exist today (11,14). In addition to this lived experience of colonialism, racism and inability to pursue self-determination, health inequalities in Métis peoples have also been particularly influenced by social exclusion and loss of Indigenous language due to cultural assimilation (10,12).

The indicators selected for this report are useful for highlighting health inequalities that exist between Indigenous and non-Indigenous peoples and for gauging progress towards the elimination of such inequalities. However, on their own, these quantitative and largely deficit-based indicators do not adequately incorporate Indigenous concepts of health and wellness; are insufficient for creating programs and policies that contribute to improving the health of the Indigenous population; and may even be harmful if used incorrectly, as they risk continuing to label Indigenous peoples with negative stereotypes (15,16). Moreover, without adequate explanatory context about the structural factors that have impacted Indigenous communities (e.g. inadequate infrastructure funding, discriminatory policies that limited access to loans or mortgages), indicators that focus solely on the problems in these communities can reinforce discriminatory attitudes towards Indigenous peoples. Ultimately, for health planning and action to be effective, indicators must be Indigenous-specific and community-driven, taking into consideration Indigenous peoples' holistic worldviews, histories, and resources (16). A balanced approach that identifies protective factors such as resilience, self-determination, and identity provides a more complete understanding of the issue and can be more effective in empowering and mobilizing individuals or a community towards improving health.

This report draws on a number of national surveys and administrative databases to populate the indicators, including the Canadian Community Health Survey, Canadian Vital Statistics Database, and the Canadian Cancer Registry. While many of these sources capture data for First Nations people living off reserve, the Métis and the Inuit, most exclude First Nations people living on reserve and in northern communities. Helping to fill this information gap is the First Nations Regional Health Survey (RHS), the only First Nations–governed national health survey in Canada. The RHS, coordinated by the First Nations Information Governance Centre (FNIGC) in collaboration with its 10 Regional Partners, collects information about First Nations people living on reserve and in northern communities based on both Western and traditional understandings of health and well-being. In the present report, where applicable, national-level RHS data and contextual information for First Nations people living on reserve and in northern communities are provided by FNIGC. PHAC has worked in partnership with FNIGC to ensure that the inclusion of on-reserve First Nations data in this report is in compliance with the First Nations principles of OCAP® (Ownership, Control, Access and Possession).

FINDINGS

Overall, significant health inequalities were observed among Indigenous peoples, sexual and racial minorities, immigrants, and people living with functional limitations, and a gradient of inequalities by socioeconomic status (income, education levels, employment, and occupation status) could be seen for many indicators. Some populations (in particular, those with lower socioeconomic status as well as First Nations, Inuit and Métis peoples) had consistently less favourable results, while other groups (e.g. recent immigrants and racial minorities) experienced mixed outcomes in terms of health behaviours, health outcomes, and structural determinants of health.

Health Outcomes

Life expectancy and mortality. Clear socioeconomic gradients were observed across life expectancy and mortality indicators. **Life expectancy** and **health-adjusted life expectancy** were consistently lower and **infant mortality** and **unintentional injury mortality** were consistently higher among those living in lower-income areas, with lower educational attainment, and with greater material and social deprivation. These health outcomes were also worse in areas with a high concentration of First Nations, Inuit, and Métis people. Similar socioeconomic gradients by income, education, and material and social deprivation could be seen for **suicide mortality**. Suicide mortality was also relatively high in areas with a high concentration of First Nations, Inuit, and Métis people, and particularly high among men living in areas with a high concentration of people identifying as Inuit. Across all social stratifier groups, suicide mortality was higher among men than women.

Mental health and mental illness. Low **self-rated mental health** (SRMH) was more common among those with the lowest income, lower levels of educational attainment, and unskilled and semi-skilled occupations, and decreased as socioeconomic gradients increased. Low SRMH was also more common among those identifying as bisexual or gay/lesbian compared with those identifying as heterosexual.

Clear socioeconomic gradients were likewise observed for **mental illness hospitalizations**, which increased with each step-wise decrease in neighbourhood income and educational attainment levels, and with each step-wise increase in material and social deprivation. Also, in areas with a high concentration of people identifying as Métis, Inuit, or First Nations, mental illness hospitalization rates were two to three times the rate among people who live in areas with a low concentration of people identifying as Indigenous.

Cause-specific outcomes. Compared with employed adults, those who were permanently unable to work reported significantly higher prevalence of **arthritis**,

asthma, and **diabetes**. Similarly, people with lower income and lower educational attainment levels consistently reported higher prevalence of these chronic diseases than those in higher socioeconomic status groups. **Arthritis, asthma**, and **obesity** were less prevalent among immigrant Canadians, especially recent immigrants (in Canada for 10 years or less), than among non-immigrant Canadians. However, **diabetes** prevalence was higher among long-term immigrants than non-immigrants.

Indigenous peoples also face inequalities in cause-specific outcomes. The prevalence of **arthritis, asthma, diabetes,** and **obesity** were higher among First Nations adults living off reserve, First Nations adults living on reserve and in northern communities, and Métis adults than among non-Indigenous adults. Among Inuit adults, obesity was also higher than among non-Indigenous Canadians; results for other cause-specific outcomes were not statistically significant.

Inequalities in **disability** and poor **oral health** (inability to chew) were particularly pronounced between socioeconomic groups (by employment status, educational attainment, and income level).

Finally, based on case report data, the incidence of active **tuberculosis** was exceptionally high among the Inuit, at nearly 300 times the rate among Canadian-born non-Indigenous people. Active tuberculosis incidence rates were also very high among First Nations people living on reserve and foreign-born Canadians, at 32 times and 20 times, respectively, the rate among Canadian-born non-Indigenous people.

Health Determinants: Daily Living Conditions

Health behaviours. A strong socioeconomic gradient was evident for **smoking, exposure to second-hand smoke (SHS) in the home,** and **lung cancer incidence**: all three indicators increased as levels of income, educational attainment, and occupational skill (for smoking and SHS) decreased, and as neighbourhood social and material deprivation (for lung cancer incidence) increased. The prevalence of **smoking** among adults with less than a high school education was nearly 4 times that of university graduates, and prevalence among unskilled workers more than twice that of professional workers. Similarly, **exposure to SHS** was significantly higher among those in the lower educational attainment, occupational status, and income groups.

In contrast, **high alcohol consumption** was more prevalent among people with higher income. In terms of educational attainment, heavy drinking prevalence was lowest among university graduates and similar across other education groups. High alcohol consumption was about 3 times higher among White adults than among Black, East/Southeast Asian, South Asian, and Arab/West Asian Canadians. The prevalence of high alcohol consumption and smoking were also higher among Inuit, Métis, and First Nations people living both off reserve and on reserve than among non-Indigenous peoples.

Physical and social environments. The prevalence of **core housing need** among Canadians in the lowest income group was nearly 7.5 times as high as among Canadians in the highest income group, decreasing along a step-wise gradient, from lowest to highest income. Recent immigrants reported a prevalence of core housing need twice that of non-immigrants; the magnitude of inequality in core housing need was even higher between recent immigrants who are visible minorities compared with non-immigrants who were not visible minorities.

Health Determinants: Structural Drivers

Early childhood development. The proportion of **developmental vulnerability in early childhood** among children living in the most materially and socially deprived neighbourhoods was more than twice as high as among children living in the least deprived neighbourhoods. Similarly, this proportion was twice as high among children who were identified by their teacher as Indigenous than among those who were identified as non-Indigenous. A clear socioeconomic gradient is evident here as well, where

observed prevalence of developmental vulnerability increases as neighbourhood income and education levels decrease.

Social inequities. Low socioeconomic status was strongly related to structural drivers of inequity. For example, **household food insecurity** due to financial constraints increased dramatically as household income decreased, with the prevalence among adults in the lowest income group nearly 30 times that of adults in the highest income group. Among adults in households where none of its members had completed high school, the prevalence of food insecurity was 8.5 times that of adults in households with at least one university graduate. Food insecurity was 3.7, 2.7, and 2.2 times as prevalent among Inuit, First Nations living off reserve, and Métis adults, respectively, as among non-Indigenous adults. (The prevalence of household food insecurity was also high among First Nations people living on reserve and in northern communities, although results cannot be directly compared with the prevalence among non-Indigenous Canadians due to methodological limitations.) The prevalence of household food insecurity was also nearly 3 times higher among adults who identified as bisexual than those who identified as heterosexual. The prevalence of **working poverty** was notably higher among Canadians who had not completed high school, First Nations people living off reserve, recent immigrants, and racial minorities.

DISCUSSION AND IMPLICATIONS

Canadians are among the healthiest people in the world. However, as this report shows, the benefits of good health are not equally enjoyed by all Canadians. Some of these observed inequalities are consistent with what is known from other research on the social determinants of health and health equity, while others remain to be more fully explored. Regardless, the persistence, breadth, and depth of health inequalities in Canada constitute a call to action across all levels and sectors of society. In recent decades, the global evidence on what works to reduce health inequities has grown, making it possible to identify key principles for action and promising practices that can be adapted to advance health equity within the Canadian context.

1. **Adopt a human rights approach to action on the social determinants of health and health equity.** A human rights approach recognizes that equitable access to opportunities for health, well-being, and their determinants is an issue of fairness and justice. The right to health in particular is recognized in a number of United Nations covenants and conventions to which Canada is a party, including the International Covenant on Economic, Social and Cultural Rights. Implementation of a human rights approach to health can be supported by evidence-based, participatory, and coherent action across governments and sectors, including working with communities most affected by health inequalities to design interventions that are both relevant and effective.

2. **Intervene across the life course with evidence-informed policies and culturally safe health and social services.** Advantages and disadvantages in health and the distribution of its social determinants accumulate over an individual's life course and over generations. Interventions at different life stages, particularly during critical or sensitive periods (e.g. early years) can substantially affect health outcomes and health equity.

3. **Intervene on both proximal (downstream) and distal (upstream) determinants of health and health equity.** Public health actions that focus on individual-level behavioural determinants may inadvertently increase health inequalities in the absence of accompanying efforts that target "upstream" socioeconomic, political, cultural, and environmental factors.

4. **Deploy a combination of targeted interventions and universal policies/interventions.** Policy and program interventions may be specifically targeted towards those with the poorest health

outcomes and greatest social disadvantage or they may be designed for universal delivery across the whole population but implemented at different levels of intensities depending on the varying needs of specific sub-groups ("proportionate universalism"). Pairing targeted and universal interventions helps ensure that the targeted intervention effects are not "washed out" by broader conditions that may sustain social inequalities.

5. **Address both material contexts (living, working, and environmental conditions) and sociocultural processes of power, privilege, and exclusion (how social inequalities are maintained across the life course and across generations).** Both material deprivation and sociocultural processes that maintain privilege and disadvantage and inclusion and exclusion play important roles in generating and reinforcing social and health inequities. In addition to addressing material conditions, effective action on health equity must also include efforts to empower disadvantaged communities and tackle the harmful processes of marginalization and exclusion (e.g. systemic discrimination and stigmatization) embedded in hierarchies of power and privilege.

6. **Implement a "Health in All Policies" approach.** Recognizing that many of the policy levers that influence the social determinants of health lie outside of the health sector and, as such, can only be addressed through collaborative engagement with others, WHO has developed a "Health in All Policies" framework to support government sectors in systematically taking into account the health implications of their policy decisions in order to better avoid harmful health impacts and improve population health and health equity.

7. **Carry out ongoing monitoring and evaluation.** Improving population health and health equity requires current, systematic, and robust evidence to inform policy actors, practitioners, community organizations, and citizens about how health and its determinants are distributed across subpopulations, and how policies and interventions affect health and health equity. Ongoing monitoring and reporting on the magnitude and trends of health inequalities and their determinants supports public actors in evaluating their progress.

Ultimately, achieving the goal of health equity demands that we acknowledge our interdependence—our shared responsibility to create and sustain healthful living and working conditions and environments, and the shared benefits that we can all enjoy when those conditions are in place. Tackling health inequities requires effort, innovation and ingenuity, but Canadians are up to the task if we apply our collective will and wits in service of our common good.

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